PostScript

LETTERS

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Diagnosis and exclusion of gonorrhoea in women

The recent report[1] of the death of rectal and throat sampling in women was an exaggeration. I write lest anyone think there has been a conversion from long held,[2 3] and recently reiterated[4 5] views. Bradbeer and Mears questioned the utility of taking rectal and throat swabs in female gonorrhoea contacts by reference to a poster presentation, of which I was a co-author, at the IUSTI Asia-Pacific Conference 2002.[6]

In this poster the conclusion stated that: ''At this clinic rectal microscopy and culture, and throat culture in women did not aid diagnosis. There appears to be a general reduction in the usefulness of these tests since the last major assessment.'' The authors offered one possible explanation (of several) for this but did *not* conclude (as implied by Bradbeer and Mears' citation) that these investigations could be abandoned.

While it is vital that we have sensitive and specific methods for *diagnosing* STIs, including gonorrhoea, we have always, even during the post-war mode of gonococcal incidence, the mid-1970s, spent most of our time *excluding* gonorrhoea. We need to be able to tell, with confidence, those who ask us, that they have *not* got gonorrhoea. Further, we need to be able to reassure those treated that the infection has been eliminated. One conclusion from our study, which we hope to publish after peer review, may well be that the testing protocols adhered to in 2001 were inadequate to exclude gonorrhoea. Their adequacy would not improve were we to abandon samples from rectum and oropharynx.

For the record, the correct citation (their reference 11) and order of authors is as given here.[6] We did not suggest limiting swab sites to the urethra and cervix; the number of rectal investigations was not (as implied) 338, but 115 by culture and 94 by microscopy; throat swabs numbered 119. Finally, we did not see ''338 cases of female contacts of GC.'' The number of female contacts of gonorrhoea seen and reported in our series was 101.

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doi: 10.1136/sti.2004.009720
Accepted for publication 26 February 2004

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Barriers to HIV testing: a survey of GUM clinic attendees

HIV testing forms an important part of the national strategy for sexual health and HIV of the UK government. It proposes that all genitourinary medicine (GUM) clinic patients who are attending for ''their first screening for sexually transmitted infections''[1] should be offered an HIV test. Previous research has suggested that uptake of HIV testing in antenatal clinics is midwife dependent and possibly doctor dependent within the context of the GUM clinic.[2 3] The aim of this study was to identify factors associated with being offered an HIV test and having an HIV test in an inner city sexual health clinic with a universal HIV testing policy before publication of the government's national strategy for sexual health and HIV.[1]

We conducted a prospective questionnaire based survey of all patients of unknown HIV status presenting over a 2 month period. All patients who saw a doctor, except those attending for follow up, were invited to participate. The main outcome measure was the offer and uptake of HIV testing.

A total of 585 (49.4%) questionnaires were returned. There were no significant differences between responders and non-responders in terms of sex, age, STI, or HIV prevalence; 78.0% of eligible patients reported that they were offered an HIV test. The offering of an HIV test was associated with the patient's ethnicity, intention to test, use of class A/B drugs, and previous STI diagnosis (table 1). This difference remained after controlling for language. No significant difference was observed in patients' intention to have a test according to ethnicity (30.1% for white patients versus 21.0% for non-white patients, $p = 0.103$). The offering of an HIV test was not associated with whether the doctor was in training, routinely conducted an HIV outpatient clinic, or was male or female.

The uptake of HIV testing (42% overall) was associated with an HIV test being offered, partner numbers, having new partners while abroad and/or unprotected sex, and previous STI diagnosis. None of the patient's sociodemographic characteristics considered (including their ethnicity) were significantly associated with HIV testing uptake. Patients for whom English was not their first language were more likely to test than patients whose first language was English ($p = 0.014$). There was no significant difference in uptake according to doctor's training status, or whether they conducted an HIV clinic.

Despite relatively high rates of offering and uptake of HIV testing, there were disparities between different groups within the population. Some of the more vulnerable groups within the community appeared less likely to be offered HIV testing despite having the same uptake if a test was offered. Factors that may contribute to the disparity in offering of HIV tests include the clinician's perception of the patient's risk, prejudice (both on a personal and institutional level) and time constraints of staff. The British Co-operative Clinical Group identified ''lack of time'' as the most common reason that HIV testing was not offered.[4] With increasing numbers of healthcare practitioners becoming involved in sexual health care, appropriate standards of practice need to be maintained to ensure equity of access to HIV testing.

Acknowledgements

We thank R French and R Power for help with design of the questionnaire. The authors acknowledge with considerable gratitude the efforts of staff at Archway Sexual Health Clinic for their enthusiasm in implementing this study.

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doi: 10.1136/sti.2003.007682
Accepted for publication 26 February 2004

Sources of support: Funding for data entry from Archway Sexual Health Clinic.

Conflict of interest: none.

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